Office of Civil Rights & Title IX

COVID-19-Based Arrangements/Modification Request Form

Employee Name __________________________ LSU E-mail____________________

Phone Number ___________________________ Job Title______________________

Department _____________________________ Regular Work Hours ___________

Immediate Supervisor ____________________ Department Head______________

I am seeking to

___ Teach/work synchronously remotely from non-campus location

___ Teach/work synchronously but virtually from a campus facility (without students in the physical classroom)

___ Other (please specify accommodations/modifications sought)

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Duration of request for accommodations/modifications

___ Present through Fall Semester 2021

___ Other (please specify and provide rationale)

____

____

_____ I have been vaccinated for COVID

_____ I have not been vaccinated for COVID

Rationale to support request for accommodations/modifications:

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Rationale supporting that existing workplace accommodations/modifications are insufficient:

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EMPLOYEE MUST ALSO HAVE HEALTHCARE PROVIDER COMPLETE THE MEDICAL PROVIDER'S CERTIFICATION, ATTACHED TO THIS FORM

Consent for Release of Information: I, ____________________________________, hereby consent for the LSU Office of Civil Rights and Title IX to internally share pertinent information with necessary University personnel for the sole purpose of determining eligibility and implementation of any accommodations/modifications requested or deemed necessary.

EMPLOYEE SIGNATURE___________________________ Date____________________

Return all documents to:
Jennie Stewart, ADA Coordinator
118 Himes Hall
employeeacc@lsu.edu

Office of Civil Rights & Title IX

COVID-19-Based Further Arrangements/Modification Medical Provider Certification

Employee Name ____

Name of Healthcare Provider: ____

Medical Provider Address:

____

____

____

Phone Number: _________________ E-mail address: __________________

Further Accommodations/Modifications Recommended: (Please check and describe)

____ Enhanced Social Distancing. How many feet apart: _______________

____ Separate/limited Workspace Area.

(Description of Altered Workspace Parameters) _________________

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____Additional Protective Equipment (Please describe)

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____ Alterations to work schedule. (Description of Altered Work Schedule)

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____ Offsite work. (Description of Parameters, including proposed length of time)____

____ Other. (Please describe in full detail)

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Rationale for recommending workplace accommodations/modifications due to COVID 19 risk:

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Rationale why existing protective measures do not suffice:

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____
____
____

Duration of recommended accommodations/modifications ____________________

Has employee been vaccinated against COVID? ___ yes ___ no

If not, is the employee medically advised not to receive vaccine?
___ yes ___ no

Physician Signature: ______________________________ Date: ____________

Return all documents to:
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